younger adults and be increased gradually to minimize side effects and identify low-dose responses.

Although few data are available from well-controlled clinical trials, these findings and clinical experience indicate that most psychotropic drugs used for younger adults are also effective in elderly patients. The choice of a particular medication depends on its side effects, given the similar efficacy within psychotropic drug classes. A low dosage of a high-potency neuroleptic drug, such as 0.5 mg to 2 mg of haloperidol in 24 hours, may lessen agitation and psychosis and have minor anticholinergic and cardiovascular effects. A clinician should reassess efficacy over time, however, because akathisia or motor restlessness develops in many patients, which is sometimes confused with the underlying agitation. Clinical trials indicate that antidepressant response rates for geriatric depression range from 30% to 80%. Tertiary amine tricyclic antidepressants, such as doxepin hydrochloride starting at a dose of 25 mg, appear to help agitated depressions; secondary amine agents, such as nortryptiline hydrochloride, tend to decrease retarded depressions. Benzodiazepines are useful in treating insomnia (for instance, temazepam, 15 mg an hour before bedtime) or daytime anxiety (lorazepam in 0.5-mg increments). Benzodiazepines with long half-lives tend to accumulate in the blood, are more likely to cause side effects, and their use should be avoided.

Nonpharmacologic measures should always be attempted before using medications and often complement pharmacologic approaches. Psychotherapy is effective for many forms of geriatric depression. Anecdotal reports suggest that insomnia sometimes abates with such simple remedies as eliminating daytime napping and taking hot milk and tryptophan, 0.5 to 1 gram, at bedtime, although definitive data from controlled studies are lacking.

GARY W. SMALL, MD
Los Angeles

REFERENCES

Gerson SC, Plotkin DA, Jarvik LF: Antidepressant drug studies, 1964 to 1986: Empirical evidence for aging patients. J Clin Psychopharmacol 1988; 8:311-322

Small GW: Psychopharmacological treatment of elderly demented patients. J Clin Psychiatry 1988; 49(suppl):8-13

Small GW: Tricyclic antidepressants for medically ill geriatric patients. J Clin Psychiatry 1989; 50(suppl):27-31

The Homeless Mentally Ill

HOMELESSNESS among mentally ill persons is but one symptom of the lack in this country of a comprehensive system of care for the chronically mentally ill generally. With the advantage of hindsight, we can see that the era of deinstitutionalization was ushered in with much naivete and many simplistic notions about what would become of the chronically and severely mentally ill. The importance of psychoactive medication and a stable source of financial support was perceived, but the importance of developing such fundamental resources as supportive living arrangements was often not clearly seen or at least not implemented. "Community treatment" was much discussed, but there was no clear idea what it should consist of. The resistance of community mental health centers to providing services to the chronically mentally ill was not anticipated, nor was it foreseen how reluctant many states would be to allocate funds for community-based services.

In the midst of valid concerns about the shortcomings and antitherapeutic aspects of state hospitals, it was not appreciated that the state hospitals fulfilled some crucial functions for the chronically and severely mentally ill. The term *asylum* is in many ways an appropriate one, for these imperfect institutions did provide asylum and sanctuary from the pressures of the world with which, in varying degrees, most of these patients are unable to cope. Further, these institutions provided such services as medical care, patient monitoring, respite for patients' families, and a social network for the patients, as well as food, shelter, and needed support and structure.

In the state hospitals, the treatment and services that did exist were in one place and under one administration. In the community, the situation is very different. Services and treatment are under various administrative jurisdictions and in various locations. Even mentally healthy persons have difficulty dealing with a myriad of bureaucracies, both governmental and private, and getting their needs met. Further, patients can get lost easily in the community compared with a hospital—they may have been neglected, but at least their whereabouts were known. It is these problems that have led to the recognition of the importance of case management. Many of the homeless mentally ill would probably not be on the streets if they were part of the caseload of a professional or paraprofessional case manager trained to deal with the problems of the chronically mentally ill, to monitor them—with considerable persistence when necessary—and to facilitate their receiving services.

The concept of asylum and sanctuary becomes important because while some chronically mentally ill patients eventually attain high levels of social and vocational functioning, many others cannot meet simple demands of living on their own, even with long-term rehabilitative help. Many consciously limit their exposure to external stimuli and pressure, not from laziness but from a well-founded fear of failure. Professionals must realize that whatever degree of rehabilitation is possible for each patient cannot take place unless support and protection—whether from family, treatment program, therapist, or board and care home—are provided at the same time. If we do not take into account this need for asylum and sanctuary in the community, living in the community at all may not be possible for many patients.

H. RICHARD LAMB, MD
Los Angeles

REFERENCES

Bachrach LL: Asylum and chronically ill psychiatric patients. Am J Psychiatry 1984; 141:975-978

Lamb HR (Ed): The Homeless Mentally Ill: A Task Report of the American Psychiatric Association. Washington, DC, American Psychiatric Association, 1984

Neuropsychiatric Aspects of HIV Infection

PROFOUND PSYCHIATRIC and neuropsychiatric complications of the acquired immunodeficiency syndrome (AIDS) have been recognized since this condition was defined in 1981. Organic mental syndromes include affective, delusional, and dementing disorders. A primary AIDS dementia complex, related to direct effects of human immunodeficiency virus type 1 (HIV-1) on the central nervous system, has been described. It may affect about a third of all patients with AIDS and involves deficits in remembering, concentrating, and learning new information, mental slowing, and mood and motor symptoms all in the presence of a clear consciousness.

Currently in question are how early, and under what circumstances, infection with HIV-1 involves the central nervous system and how this relates to psychiatric morbidity. Early entry into the central nervous system appears to be